Flora Cornish

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Flora Cornish

Department of Social Psychology

London School of Economics & Political Science

Houghton St

London WC2A 2AE

f.e.cornish@lse.ac.uk

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Abstract

To understand the role of context in constituting health is recognised as a key challenge facing contemporary health psychology. However, few models or theories are available which pinpoint the processes linking individual health with community or societal contexts. This paper draws on dialogical and sociocultural psychological theory, to make context concrete by proposing the concepts of 'mediating moments' and 'reflected mediating moments'. These concepts are further developed through their application to the empirical case of the constitution of condom use in sex-worker-client interactions in Calcutta. Interviews and group discussions with sex workers and other 'red light area' residents are interpreted to examine at what moments the societal phenomena of poverty and gender relations come to mediate condom use behaviour.

A key contemporary challenge in health psychology is the question of how to conceptualise the relations between individual health and community, socio-political, economic and cultural contexts (Marks, 1996; 2002; Murray, 2000; Bandura, 2000). Marks, for example, asks: 'How are social equity and justice mediated at the community and individual levels to determine well-being?' (Marks, 1996, p.18). This question calls for analyses which specify the mediating links between individual, community and societal phenomena, but there are few theories in community health psychology that meet this task. In this paper, I draw on dialogical and sociocultural theories to make context concrete by grounding it in local interaction. The effort to concretise context is oriented to the community health psychology commitment to promoting health-enhancing contextual change.

This paper has three sections. The first evaluates the models of the health-society relation available in health and community psychologies, pointing to the need for greater elaboration of the processes linking health behaviour and societal context. The second draws on dialogical theory and socio-cultural psychology to propose the concept of mediating moments to articulate the manifestation of societal phenomena in health-related behaviour. The third section demonstrates and elaborates this concept in dialogue with empirical data on the practice of sex work in Calcutta.

Models of the health-society relation in health psychology

Pursuit of Marks' question leads us to community health psychology's 'contextualist' literature, which locates health behaviours and outcomes in their community and societal contexts (e.g. Orford, 1992; Rappaport, 1977; Marks, 2002; Prilleltensky & Nelson, 2000). In this literature, the conceptual apparatus available to direct our

thinking about context has largely taken the form of models which depict the biological individual at the centre of a hierarchical system of concentric circles (or at the bottom of a linear system), representing qualitatively distinctive 'levels' which progressively increase in scale, for example, from individual, to community, to society (e.g. Thompson & Kinne, 1999). Each consecutive level is conceived of as a broader 'context' for the individual, but such models, while highlighting the importance of macro contexts, tend implicitly to separate the macrosocial level from the level of health behaviour – thus creating the problem of how these two 'levels' are interrelated. Two contrasting modes of conceptualising the operation of such 'levels' can be identified – an aggregative and an integrative.

Biopsychosocial model: an aggregative model

The longstanding biopsychosocial model proposed by Engel (1977) has been foundational to health psychology (e.g. Sarafino, 1994). Engel (1977) argued that health care practitioners needed to conceptualise disease in terms broader than biomedicine's reductionist focus on biochemical and neurophysiological processes. He called attention to the importance of psychological factors in disease aetiology, and to the role of psychological and social factors in successful communication between doctor and patient. Thus, the psychological and social contexts of the physical body and of biomedical practice became legitimate objects of study. But, does this model give us purchase on Marks' question concerning the processes linking society, community and individual health outcome?

Despite Engel's claim to transcend the biomedical model, a prevailing critique of the biopsychosocial model and its implementation has been that, in fact, it has failed to challenge the dominance of the biomedical model, by accepting that biomedicine has access to the fundamental and universal physiology of disorder, while contextual psychological and social factors are merely appended layers. For example, Ogden (2002) argues that the biopsychosocial model accepts a dualism between biological and psychological, where the 'physical body is presented as the essential hardware to be moderated by the optional psychosocial software' (p.83). And, focusing on the constitutive role of culture, Armstrong criticises the biopsychosocial model for failing to apprehend that 'the very concept of disease, in being evaluative, is a reflection not of biological norms but of social ones' (2002, p.70). To recognise that concepts such as disease, disability, gender or age-group are socially and culturally constituted is to suggest that the individual at the heart of the system does not pre-exist society, to later become affected by society, but is thoroughly societally constituted (Tolman, 1999).

Secondly, and relatedly, by assigning biological, psychological and social phenomena to qualitatively distinct levels of a system, the biopsychosocial model does not propose theoretical relationships between biological, psychological and social levels of analysis (Crossley, 2000). Health behaviour research following the biopsychosocial model typically seeks to identify individual biological, psychological, and social variables, which can be aggregated together to predict a particular health outcome or behaviour (e.g. Botha, du Plessis, van Rooyen & Wissing, 2002). This approach contributes clear statements on the wide range of variables implicated in health-related behaviour or outcome, from biological to societal. However, the statistical association between psychological or social variables and health rarely provides

insight as to the processes or mechanisms linking the identified dependent and independent variables.

A similar epistemological position obtains in sociological analyses in which statistical associations between societal conditions and population health are sought. Such analyses contribute very important findings on the large and pervasive influence of societal factors (such as income distribution and gender relations) often neglected in biopsychosocial analyses, on the patterning of health (e.g. Carroll, Davey Smith & Bennett, 2002; Upadhyay, 2000). However, this form of analysis cannot explicate the precise processes bringing about such differential patterns of vulnerability, and thereby offers little to those seeking to develop health promoting interventions on the ground (Dowsett, 1999; Moatti & Souteyrand, 2000). For Dowsett, 'the challenge is to come up with a macro-social view that adds to a workable response to the [HIV/AIDS] pandemic instead of one that overwhelms our capacity to act' (1999, p.101). For this paper's aim to explore the precise processes linking health to societal relations, we have to go further than aggregative models of 'context-as-variable'.

Bronfenbrenner's ecological model: an integrative model

Community psychology has perhaps taken the lead in forcing attention to societal and local contexts onto health psychologists' agendas, and Bronfenbrenner's (1979) ecological model of human development has been a key resource for understanding the 'person-in-context' (e.g. Nelson & Prilleltensky, 2000; Orford, 1992). Bronfenbrenner's model distinguishes four levels of systems of increasing distance from the person, while always emphasising the relationships between the systems.

Firstly, the 'microsystem' is the concrete interactional setting of a particular activity experienced by a person. The 'mesosystem' is the system of linkages between a person's microsystems. 'Exosystems' are those settings in which the person is not an active participant, but which affect, or are affected by, that person's microsystem. These exosystems are not abstract, they are other people's concrete microsystems. Finally, the 'macrosystem' refers to a cultural and ideological 'blueprint' which yields regularities among the constituent settings experienced in a particular society or subcultural group. The qualities of a microsystem are shaped by macrosystem factors of culture, ideology, and so on. That is, these factors do not happen at a remote societal "level" but come to life in the microsystem itself. What is particularly notable in Bronfenbrenner's approach is that each of the systems is defined relative to the concrete, experienced setting of the person's microsystem. An exosystem cannot be identified absolutely, it can only be defined with reference to the means through which it influences a microsystem. Here, the social context is not abstract or remote from the individual, but is concretised in specific interpersonal relationships, and relations among these. However, the means through which the macrosystem enters into a microsystem is not clearly specified by Bronfenbrenner, and it is this question that drives the current paper. It is Bronfenbrenner's spirit of concreteness that I seek to develop in the following theoretical section.

While community psychology has taken cues from Bronfenbrenner, it is far from being stabilised on an ecological footing. The field makes continual efforts to avoid slippage into reductive or individualistic language and theorising (Fryer, McKenna & Hamerton, 2000; Rappaport, 2000; Smail, 2001). Rappaport (2000) suggests that psychology's cultural bias towards individual-centred thinking is the source of a

continual return of person-blame problem definitions, and calls for the adoption of theories and metaphors that evoke images of social and political collective action rather than of health and illness. I have suggested that metaphors of segregated levels of context, while foregrounding community and societal factors, do not facilitate theorising of the integration of individual and social – a split which is still a problem in community psychology (Hunt & Crow, 2000). To link individual and societal 'levels', I ask the question: <u>How do societal phenomena become active in the mediation of everyday health-related behaviour?</u> The next section draws on dialogical theories to propose the concept of a 'mediating moment' as a means of addressing this question.

The dialogical approach

Dialogical theory is broadly rooted in a Hegelian, as opposed to a Cartesian tradition of philosophy (Marková, 1982; 2000a). Hegelian philosophy begins with processes rather than static objects, arguing that the activity and creativity evident in living processes cannot be accounted for in the mechanical universe of Cartesian geometry. At the heart of the approach are relationships rather than elements, change processes rather than stable states, and processes of mutual constitution rather than one-way, cause-effect determinism (Marková, 1982; Mead, 1936). Whereas the Cartesian paradigm starts with objects, to later observe relations between them, in the Hegelian paradigm, objects arise out of relationships, and as relationships change, thus the objects change. A central advantage of this paradigm, for community health psychology, is that the possibilities of social change are always to the foreground, and for the current paper, objects (such as societal phenomena) exist as they arise in actual concrete relations.

Where does this dialogical paradigm lead us, in the investigation of societal phenomena? Let us begin with Vološinov's (1973) critique of structuralist linguistics, to sketch the character of a dialogical approach to societal phenomena. Saussure's structuralist model of language separates the abstract formal structure of language (*langue*) from its everyday usage (*parole*), privileging the former. Here, the meaning of an utterance is governed by its position in the abstract system of *langue*. Vološinov's critique reversed this hierarchy. He demonstrated (as have many other theorists of language) that the meaning of an utterance could not be considered independently of its use in a concrete context, which is jointly produced by speaker and addressee. Meanings are thus never fixed, but always in production - each time a word is used anew, its meaning is changed, as it absorbs a new flavour from its new context (Bakhtin, 1986). In the terms of a process philosophy, in this Bakhtinian view of dialogue, the meaning of a word is not absolute or abstract, but arises within a web of contextual relations.

A similar rejection of structural abstraction is manifest in Berger and Luckmann's (1966) sociology of knowledge. As they argue, social order (such as roles, institutions, norms) is continually being produced in interactions between individuals, it is not an autonomous entity, existing 'out there', in and of itself. They write:

> Both in its genesis (social order is the result of past human activity) and its existence in any instant of time (social order exists only and in so far as human activity continues to produce it) it is a human product (1966, p. 70).

Here, as with Bakhtin's conception of language, society is constituted and reconstituted in the ongoing activity of the everyday. Rather than identifying circumscribed individual or societal causes of a behaviour, in this view, societal and individual are inter-twined, as they are mutually constituted in a reciprocal relationship (Marková, 2000a; 2000b). If social order is constituted out of ongoing interaction, it may be negotiable and disruptable, and thus open to gradual change. However, we cannot forget that there are important inequalities in the extent of people's opportunities to participate in the production of their respective environments.

Before the complexities and indeterminacy of process and mutual constitution appear to make community health impossible to analyse, let us turn to the psychological application of such ideas, in activity theory.

Activity systems

Within psychology, activity theory has systematically developed a dialogical approach, starting with processes (activities) rather than individual or social elements (Cole, Engeström & Vasquez, 1997; Engeström, Miettinen & Punamäki, 1999; Leont'ev, 1978). The basic unit of analysis is the 'activity system', which centres on the collective (or joint), culturally mediated activity around a particular object or goal (Engeström & Miettinen, 1999). A classroom situation, of teacher and pupils engaging with subject matter, is an example of an activity system. Within this scheme, words (or other cultural resources) co-ordinate the activity of the participants. A person uses a word or a tool in an individual way, to meet an individual goal, or to

mediate another's action, but those words or tools have been historically and culturally produced, and thus the individual's action is fully cultural. In this way, the societal phenomena of language, representation and ideology suffuse the activity system.

The activity system cannot be defined separately from the processes that constitute it. Both the whole (the activity system) and the parts (the shared object(s), the participants, the goals, the cultural resources) only come into being through the web of relations that is the whole integrated activity. While the participants engage in different actions, they fit together as a whole within the context of a shared goal or motive (Leont'ev, 1978). An activity system is localised and concrete, but simultaneously societal. The participants, their goals and resources are understood to be societally produced (Tolman, 1999). Furthermore, societal structures are seen as products of local activities – though the activities of their production may take place in inaccessible government departments or corporate boardrooms (Engeström, 1999). The activity system corresponds to Bronfenbrenner's relational microsystem, but provides greater theoretical specificity in concepts (cultural resources, shared goals, activity) which pinpoint societal phenomena in everyday practices.

Mediating moments: making 'context' concrete

To further pursue the process through which societal phenomena enter into the movement of the activity system, I want to argue for the 'concreteness' of context. This will return us to our guiding question, equipped with the resource of a 'mediating moment' to tackle it. Vygotsky (1935/1994) argues that a person's environment cannot be described abstractly, or absolutely, as having objective properties, but rather, that

its relevant properties emerge in relation to the person's particular needs, interests and capacities. To illustrate this assertion, he presents a case study of three children of an alcoholic mother, each of whose development was affected in a unique way by their family environment. It was in meeting with the specific capacities and needs of each child that the mother's alcoholism (the context) came to affect the child's development.

This argument demands that the environment be conceptualised concretely. As Tolman (1999) explains, when something is understood concretely (in a Marxist sense), it is densely linked in a set of specified relations, as opposed to 'abstract' theorising which strips a phenomenon of its relationships. He argues that by correlating environmental with personal variables to understand a particular pattern of development or behaviour, we create a further abstraction, but do not find the underlying connecting processes which link that behaviour to its environment. As Valsiner (1998) argues, causation does not occur amongst abstracted social factors, but in the flow of actual events as they happen.

The point I want to take from this discussion is that if societal phenomena (such as poverty or gender relations) are found to be related to health outcomes, then there must be a moment at which we can pick out the operation of the societal factor in the flow of action. I will call such moments 'mediating moments' – referring to the moment, or event, within the flow of activity, when the social factor becomes operative and mediates the health-related behaviour.

Reflected mediating moments

Not only do societal phenomena enter into activity, in mediating moments, to shape people's behaviour, but such mediating moments can themselves be grasped or represented by the actors. In recognising the ways in which societal factors are operative in our everyday world, we can respond reflexively to that societal environment, to change it, or to change its effect on us (Marková, 2000a). I will use the term 'reflected mediating moments' to refer to the specific moments, or events, in which the representation of a social phenomenon mediates health-related behaviour.

This is the logic behind Paulo Freire's (1970; 1973) dialogical theorisation of 'conscientisation' as the route to social change. In conscientisation, communities of social actors interact to 'name the world'. In this process, community or societal structures which disadvantage a community are brought into collective debate, alternatives can be envisioned, and individual and collective action can be taken, aiming to reformulate social structures in the interests of the actors. One of the methods for stimulating conscientisation is the dialogical contrasting of a group's current situation with alternatives existing for different groups within the same society (Montero, 2002).

In the terms of activity theory, a new cultural resource is created by a community coming to represent an environmental source of their disadvantage, and that cultural resource can create a new goal or offer new actions. Moreover, for the cultural resource to be sustained, it must be embedded in an activity system, and thus, be employed to co-ordinate an activity. In the context of our question, it is the moment

when these cultural resources are actively employed, to mediate ongoing activity, that is of interest, and this is what I have called a reflected mediating moment.

This theoretical discussion has aimed to contribute the concept of mediating moments to integrative models of the society-health relation, in order to focus attention on the nodal points when societal phenomena become active in behaviour. Building on Bronfenbrenner's localisation of 'context' in observable interactions, I have suggested that, within these interactions (in the microsystem or activity system), we can pick out moments when community and societal factors are operative, and thus, that the societal 'levels' take place at the 'level' of concrete interaction. The next section demonstrates these ideas through an empirical case study.

Empirical instantiation: Condom use in sex worker-client interactions

My aim, in what follows, is not to present a full empirical account of each factor implicated in condom use among sex workers. Rather, I have the more focused theoretical aim of elaborating the concept of mediating moments through examining their concrete instantiation. The data discussed here are drawn from an investigation of factors shaping condom use, which is part of a larger project examining the role of participation and community action in HIV prevention among female sex workers in Calcutta. In this paper, discussion of six points at which societal economic and gender relations enter the sex-worker-client interaction aims to further elaborate the concept of mediating moments.

The research setting

The study is centred in Sonagachi, Calcutta's largest 'red light area', in which an estimated 5,000 sex workers live and work (Jana & Banerjee, 1999). The sale of sex is the central commercial activity here, providing employment and income not only to sex workers, but indirectly to brothel managers or agents, landlords, domestic workers, taxi-drivers, vendors of food, drink, clothes and cosmetics. This research takes place with the help of the 'Sonagachi Project', an HIV prevention and community development project for sex workers, run by Durbar Mahila Samanwaya Committee, a sex workers' collective. The project was set up in 1992 by a coalition of sex workers, local academics, NGOs and donors. Project documentation describes its philosophy in terms of '3 R's: Respect, Recognition and Reliance. That is respect of sex workers and their profession; recognising their profession, and their rights; and reliance on their understanding and capability' (Jana & Banerjee, 1999, p.11). Sex workers are involved in all, and lead many, of the project's decision-making and intervention activities. Health education about safer sex, condom promotion and bringing sex workers to sexual health clinics are the health-related foci of the project.

Methods: Interviews and group discussions

In the interests of preserving the local concreteness and complexity of the organisation of (health-related) behaviour, a community case study, based on semi-structured interviews and group discussions, was chosen as the research strategy. A dialogical operationalisation of the concept of 'community' relies neither on geographical nor on social-identity boundedness but considers that a 'community' is

constituted out of repeated patterns of interaction around a particular activity. In this case, our interest is in the community that is constituted in activity systems concerned with the sale of sex, composed of members often with different interests and different degrees of power, who, nonetheless, have to collaborate and live together.

Semi-structured interviews and group discussions among three categories of participant were used: 10 group discussions (each with 4 to 8 participants) and 11 interviews with sex workers who have little involvement in the project; 15 interviews with project workers (sex workers employed by, or committee members of, the project); and 20 interviews with diverse non-sex-worker local people (project staff, clients & boyfriends of sex workers; brothel managers; landladies). The group discussions were formed of 'natural groups' – women from the same locality who knew each other well already.

Three topics structured the interviews and group discussions: (a) Contextual information on life-history, community structure, living and working conditions; (b) Knowledge and attitudes relating to condom use and sexuality; (c) Involvement with and appraisal of the Sonagachi Project. Participants were recruited by project workers, to form a convenience sample. In the marginal and exploitative context of the red light area, personal introductions were absolutely necessary to recruitment. To maximise the diversity in the sample, 15 different project workers were involved in recruitment. Interviews with project workers and staff usually took place in one of the clinics run by the project, all other red light area residents were interviewed in their homes or in the room of a neighbour. Interviews lasted a mean length of 1 hour, 25 minutes and group discussions 2 hours 35 minutes.

Transcribed interviews were analysed using the software package ATLAS/ti (Muhr, 1997), with the aim of identifying the set of factors shaping condom use in the sex-worker-client interaction. All of the participants' interviews were analysed together, so that the diversity of perspectives on each code was preserved under that code. The initial 'theory-driven' coding frame was prompted by a 'levels of context' model (including lifestyle; social/community; living and working conditions; macro-environment – Marks, 1996; 2002). Analysis began by categorising segments of the interviews which identified a factor related to condom use which could be located at one of these four levels (e.g. beliefs about condoms would be at the first level and poverty at the fourth).

However, through the process of analysis, it emerged that important features were not being captured in this coding frame. Thus, the 'activity system', of the sexual encounter, with codes for sex workers' and clients' goals, and their interaction, was introduced as a new section of the coding frame, for the foundation of the interpretation. The factors which had been coded under the 'levels' were re-organised under categories which more closely reflected the data, so that in the final coding frame, the higher-order structure was provided by the code categories: 'intentions and interests'; 'negotiation'; 'sex worker-client power balance'; 'others' control over the sexual encounter'; and 'general vulnerability'. Furthermore, as I developed the concept of 'mediating moments' through the dialectical process of data-theory engagement, for each social 'factor', I specified the linking point at which it crossed from a social 'level' to the health behaviour. The interpretation presented here, for the purpose of elaborating the concept of 'mediating moment', focuses on the activity system, and on

one factor from each of the higher-order categories (two from 'power-balance'), as outlined in the table. Quotation marks are used around reflected mediating moments, to signify the reflection involved.

INSERT TABLE 1 HERE

Several aspects included in the full coding frame are excluded from this discussion. The sex-worker-boyfriend relation is not considered. The factors implicated in condom use which make up the rest of the coding frame (female sexuality; beliefs about condoms; health related arguments; tricks/ strategies; work norms & morality; love/ attraction; family's economic pressure; agents/ procurers; stigma; local hoodlums/ police) are not given full discussion in this paper, but enter as they relate to the six discussed.

We begin with a detailed description of the activity system in which condom use is situated, to provide a foundation for interpretation. The second interpretative stage unpacks the mediating moments in which poverty and gender relations become active within that activity system.

The sexual relation activity system

The exchange of sex for money, between sex worker and client, is the concrete, immediate activity system within which condom use does or does not take place. Sex workers explain that their primary interest in this relationship is to earn money, and many of them are skilled at pleasing the customer in ways likely to lead to repeat

visits or tips. Many hope to meet men who could become financially supportive long-term partners, allowing them to leave sex work. However, they typically acknowledge that, in general, boyfriends in the red light area are 'eaters' (of a sex worker's earnings) rather than 'givers', some expressing appreciation of their freedom and independence from men. As well as meeting immediate financial needs for food and rent, and sometimes debts, many women financially support their parents, siblings, or children, thereby winning appreciation and security for their old age, which are otherwise threatened by their occupying the stigmatised position of sex worker. Regarding condoms, most women are aware of their health-protective value, and value them for a sense of cleanliness and hygiene, but not necessarily for the medically-defined value. Thus, for example, project workers attributed the popularity of condoms in one area of the city to the particular scarcity of water there for washing after sex. However, given their need for income, women are sometimes unwilling to turn a customer away or to risk losing his repeat custom by insisting on condoms if he is averse to them.

For men, the main purpose of visiting a sex worker is to fulfil a natural compulsion to achieve sexual release and satisfaction, while sometimes seeking a longer-term intimate relationship. The reason that participants (both men and women) give for men visiting the red light area is that they do not get the sex they want at home, either because they are unmarried, or because they cannot have sex in front of their grown-up children (in a context where families live in one room) or their wife will not agree to the particular sexual practice, such as oral sex, which they desire. Condoms are seen by men as obstacles to sexual pleasure and satisfaction, though they are also

aware of their health-protective value, and appeals to the man's responsibility for his family's health are sometimes used by sex workers as arguments for condom use.

The present discussion covers two modes of organisation of the sale of sex. Firstly, independent sex workers rent a room, in which they live and work, directly from a landlord or landlady, and, according to their economic need, choose when and how they work. Secondly, in the *malkhin* or 'madam' system, a brothel manager (usually a former or older sex worker) employs one or more sex workers, who pay the manager 50% of their earnings, in return for accommodation, food and security. The madams enter the sexual relation activity system as intermediaries between the sex worker and client. A madam's economic interest is tied to the sex workers' earnings, and hence she is unlikely to encourage refusal of a client on the grounds of his refusal to use a condom. However, some madams let sex workers take most of the control over their work. Madams have about one to six sex workers working under them, and there may be limited space available for entertaining clients.

Under both systems, clients are usually met on the street by the sex worker, where a price is negotiated, and then they are brought inside, to the room the woman works in. If a 'known' client does not find the sex worker he knows on the street, he may approach her in her room. She may have the room to herself if she works independently, or if her madam has enough rooms. Otherwise, several sex workers share a room with two to four beds, separated by curtains. It is assumed that peno-vaginal intercourse in the 'missionary position' is the kind of sex to be performed, unless the man requests something else (most commonly, oral sex), which he will usually do after the pair enter the room. Condoms will first be mentioned at this time,

and according to the women, neither men nor women feel embarrassed to talk about sex or condoms. If he agrees to use a condom, the sex worker usually provides the condom, and fits it onto the man's penis, to ensure he does not cheat. Condoms are distributed free or for a nominal fee by the Sonagachi project, and sex workers can sometimes charge customers for the condom(s) they use. Money may be exchanged before or after sex. Tips may be added, and are not shared with madams.

If the sex worker works independently, she may have a certain amount of control in her interaction with the client. A 'good' client – one who pays well, and returns regularly – will be treated almost like a husband. The woman will offer to get him alcoholic or soft drinks (taking a commission) and will make conversation. She may tell him she loves him, and allow him to touch her body before intercourse. While sex workers usually emphasise that their friendly treatment of clients is a functional way to get a better income, they also state that with some clients they enjoy the friendship and the sexual relations. With most clients, however, sexual relations are shorter and to the point. The woman may not allow the man to touch her body, and may not undress, just 'lifting her sari', exchanging few words. Without a special relationship with a client, the woman has little bargaining power, and he takes more control over the sexual encounter. Sex workers are in a hurry to get the man out of the door as soon as intercourse is over. The man washes, dresses and leaves, and the woman prepares herself to return to the street to find another client. Compared to the collaborative emphasis typical of activity theory, the divergences of interests and power between sex worker and client are notable here.

Unpacking society-condom use mediating moments

1. Time pressures

As described above, for the purposes of a sense of cleanliness and protection of health, sex workers are often keen to use condoms, and are willing to argue with a reluctant client. They claim that, given time, they can often convince the client to use a condom. However, they are not always willing to risk taking that time. Under the madam system, there is often pressure to complete the sexual encounter quickly, in order to vacate the room for another sex worker, and to assure the madam that no more sex has taken place than agreed, or more to the point, that no more money than agreed has changed hands.

Investigating the madam system further, we find that the unwillingness of the sex worker to prolong the encounter with the client by arguing is a mediating moment for the sex worker's context of economic disadvantage and social disruption. How so? If the madam system deprives sex workers of autonomy, why do they tolerate this system when other women work independently? To rent a room for independent work requires a large downpayment and regular payment of daily or monthly rents. Moreover, recently-arrived sex workers lack business skills and the cultural knowledge of the complex organisation and norms of the red light area necessary to make a living and avoid exploitation by clients, local residents or police. Thus many women are willing to give up some autonomy for the physical and financial security of the madam system. The madam system emerges as oppressive in relation to the interest in condom use, but as protective in relation to the interest in personal security.

2. Fear of losing earnings

Exchange of money, and thereby, economic relations, are at the heart of the negotiation between sex worker and client. In accounting for the times when they fail to use condoms with clients, sex workers explain that if they have not earned any money for several days, they cannot afford to turn away a client who refuses to use a condom – they may be exposed to a disease, but at least they will not go hungry. If they try to impose condom use upon a reluctant client, they explain, he can simply leave and find another woman who will accept his conditions. Poverty becomes active at the mediating moment when the sex worker fears that if she insists on condoms, he can leave and find someone else to fulfil his demands.

However, looking closely at this economic power relation, we can see that the general situation of poverty is not the only social context coming into effect at this mediating moment. In the precise situation of the negotiation, it is the belief that other sex workers will agree to the client's demands that precipitates the woman's acquiescence. Thus, the sex worker's expectations of her peers and her need for money combine to mediate her acceptance of the client without a condom.

3. 'Unity'

Building on this logic, the Sonagachi Project tries to disrupt the effect of poverty on sex workers' acceptance of clients without condoms, by encouraging a sense of unity, and commitment to universal condom use among sex workers. Since some parts of the environment – such as local community relationships – are ongoingly produced in local interaction (unlike, say, national economic policy), some action can be taken locally. To do this, in community meetings, project workers seek to create the cultural

resources for a reflected mediating moment – naming poverty and competition among sex workers as their problem, and proposing solidarity and unity to counter these. To argue for unity, project workers compare their situation to those of other workers who have a trade union. Trade unionism is strong in Calcutta, and they argue that doctors, shoemakers and tailors have solidarity through their unions, so why shouldn't sex workers too be united?

Sex workers in one group discussion confirmed using this cultural resource. Without being asked about 'unity', they explained that they always insisted on condom use, without fear of losing business as they were confident that nobody in their area accepted clients without condoms, and they established this by speaking with their friends. This was a minority experience – other women appreciated the logic of solidarity but regretted that it did not exist for them. Needless to say, in highly competitive and conflictual situations, which often characterise red light areas, there will be many obstacles to the creation of such reflected mediating moments.

4. 'Poverty'

Whereas 'unity' enters in reflected mediating moments in response to poverty, 'poverty' itself is used at times in reflected mediating moments to argue for the necessity of condom use. One of the arguments which project workers use to convince sex workers of the value of condoms is that they cannot afford to fall sick with a sexually transmitted disease, because that would mean resting for several days and not getting any income. Then, how would they pay for meals, and wouldn't their madam be angry with them and cause them problems? When daily income is a necessity for many women, these arguments make sense. Project workers attempt to bring the idea

of 'poverty' into the sex worker's interaction with the client so that she considers the consequence of illness on her ability to earn. One sex worker brought 'poverty' explicitly into her arguments with clients. She described pleading with a reluctant client that, while he might be able to pay for treatment if he fell ill, she was too poor to pay for treatment, so shouldn't he show pity on her, and accept her request?

5. *Male demands*

For our last two examples of mediating moments, we turn from economic societal relations to gender relations. The societal construction of male sexuality enters into the sex worker-client relation through the mediating moment of the client's preferences for the sexual relation. It is assumed that men have a natural need for regular sexual intercourse. The male sexual compulsion is sometimes explained in terms of the build up of heat in the body, which needs to be released, through sexual intercourse, to maintain a healthy balance. When clients focus on sexual release and pleasure, condoms appear as distasteful and unpleasureable obstacles to achieving satisfaction. As customers, they argue that if they are paying good money, they deserve full satisfaction, which cannot be achieved with condoms.

However, this mediating moment of clients' compulsive sexuality can be dialogically engaged with by sex workers, to create an alternative mediating moment, in which the women gain a particular power. According to male interviewees, men become powerless before women with whom they want to have sex. Some women spoke of a strategy to enforce condom use based on their understanding of this apparent weakness of men. They would negotiate the price with the client first, saying nothing about condoms. Then, when he is sexually aroused, the sex worker says that a

condom must be used. At this point of arousal, he is powerless to refuse, and must agree to her terms. In this mediating moment, the sex worker takes advantage of the client's social normative environment to mediate condom use to suit her interests.

6. 'Exploitation of women'

This section turns to a more indirect, but still concrete, society-condom use relation. Here, I identify a mediating moment where societal gender relations come to affect the likelihood of sex workers achieving unity in relation to condom enforcement.

In their evaluation of their position in society, as sex workers and as poor women, many sex workers express an attitude of fatalism. Selling sex is highly stigmatised in a context in which marriage is a woman's key source of status and respect (according to many sex workers interviewed), and thus sex workers often avoid being identified as sex workers by family, friends or acquaintances. They tell people at home that they work in a factory, a nursing home, or as a domestic servant, use a different name in the red light area, and are wary of unnecessarily showing their face on the streets, particularly in conjunction with a meeting of sex workers. Furthermore, sex workers spoke of the vulnerability to sexual exploitation of poor women in general. Several women referred to common knowledge of domestic workers being raped by the men of the household. Among participants in one of the group discussions, it was a common experience to have entered sex work because, in their previous job on a construction site, providing sexual favours to their employers was a precondition to getting hired. Hence, they asserted that women are seen as sexual objects and exploited by men, whether inside or outside the red light area, and doubted that exploitation could be reduced. Thus, gender relations enter discussion – in reflected

mediating moments – but in this case, knowing that they are disadvantaged by virtue of their gender is by no means an empowering phenomenon.

Conclusion

This paper has sought to further the analysis of the contextual constitution of health by contributing dialogical concepts for the task. I began with the question: <u>How do societal phenomena become active in the mediation of health-related behaviour?</u> Following a dialogical approach, societal phenomena are made very local and concrete in the concepts of 'activity system', 'mediating moment' and 'reflected mediating moment'. I have suggested beginning an analysis of community health with a detailed description of the activity system constituted around the health behaviour of interest. Within this activity system, mediating moments can be picked out, in which societal phenomena become active, to mediate the health-related behaviour. When actors mobilise conceptualisations of the societal phenomena, to change their behaviour, reflected mediating moments arise. I hope that the notion of mediating moments supplements the 'levels' models discussed in the introduction, to stimulate more precise specification of the mode of operation of the contextual factors identified in such analyses.

In seeking to specify the local moments of society-behaviour mediation, I have not intended to undermine the very powerful effects upon health of broad societal phenomena such as economic and health service policies, or oppressive gender relations. Rather, I hope to have substantiated their role, by demonstrating the very

concrete ways in which they become active in the generation of health or ill-health. Smail (2001) criticises community psychologists for continuing to seek an individual, internal, route through which health disadvantage is produced instead of giving material, social, environmental and historical explanations. The 'mediating moment' seeks to give specificity to such societal explanations. Emerging in the flow of the activity system, the mediating moment is neither intra-psychic nor abstract.

Application of the concept of 'mediating moments' in the exploration of the data highlighted three important distinctions in the ways in which mediating moments manifest. Firstly, there is the distinction between mediating moments local to the health behaviour of interest, and directly implicated in it (e.g. fear of losing earnings or confidence in unity) and mediating moments occurring non-locally to the behaviour of interest, but nevertheless, concretely (e.g. fatalism reducing the likelihood of unity). Here, social relations happening non-locally are not abstractly invoked, but are concretely specified as they arise in interaction or experience, echoing the concreteness of Bronfenbrenner's ecological model.

Secondly, the relationship between (reflected) mediating moments and agency can be further clarified. In the theoretical discussion, agency emerged in reflected mediating moments when actors represent their societal environment so that they can intentionally and agentically respond to it. The example of the sex workers actively taking advantage of the client's compulsive sexuality seems slightly anomalous here. On the one hand, they do not seem to represent his need for sex as a norm that he is subjected to, but on the other, they enforce condom use, by strategically taking advantage of his norms. If the defining feature of the reflected mediating moment is

the 'naming' of the environment of interest, then agency is not only achieved through reflected mediating moments, but also, less reflectively, in mediating moments.

Thirdly, in the examples of sex workers orienting to male sexual norms, and seeking to generate 'unity', empowering mediating moments are achieved in two different ways: individually and collectively. The agency offered by tricking a client into using a condom is limited and individual. It can be used once only with a particular client, the sex worker risks losing a potential repeat customer if he is displeased, and it is has to be continually re-employed in the context of individual interactions with individual clients. On the other hand, since the resource of 'unity' is oriented to collectively countering the environmental condition of poverty, fully developed, its effect on condom use, would be much more general and sustainable.

Finally, I wish to draw attention to an important theoretical consideration. The reflected mediating moment of fatalism about the exploitation of women invites a challenge to interpretations of conscientisation which propose that to 'name' the structures disadvantaging one is an empowering process. On the contrary, for some sex workers, the perception, experience, and 'naming' of a pervasive gender-based stigmatisation and sexual exploitation in their society produced a fatalistic attitude of little expectation of change in the future. It may be that to identify the structures affecting one is just the first step of the conscientisation process, but it seems important to recognise that when there are few, if any, avenues through which to take action on those structures, to recognise the powerful societal sources of one's disadvantage may be experienced as profoundly disempowering rather than as empowering. That is, reflection is not always liberation.

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Table 1: The codes selected for elaboration in this paper

Code category	Code	Mediating moment
1. Activity system	sex worker's goals for the encounter	
	client's goals for the encounter	
	sex worker's interest in condom use	
	client's interest in condom use	
	the sex worker-client interaction	
2. Constitution of condom use		
Intentions & interests	client sexuality	male demands
Negotiation	'poverty' as argument	'poverty'
Power-balance	sex-worker-client economic relation	fear of losing earnings
	unity/disunity	'unity'
Others' control	madam system	time pressures
General vulnerability	sexual exploitation	'exploitation of women'